

**COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH**  
**ADVANCE HEALTH CARE DIRECTIVE**  
**ACKNOWLEDGEMENT FORM**

**Part One: For Program / Clinic Staff**

**Background**

In accordance with California Probate Code 4600 et seq. and Federal requirements under Title 42, clients 18 years of age and older shall receive information about Advance Health Care Directives and be informed of their right to make decisions about their medical treatment.

**Instructions for Completing MH Form 635**

**Step One:** At the client's first face-to-face contact or clinic visit, please provide the client/significant other/guardian with a copy of Advance Health Care Directive Fact Sheet.

**Step Two:** Please complete this form and provide the client/significant other/guardian with a copy.

Ask the client and complete the following questions:

Yes No

1. Do you have an Advance Health Care Directive?
2. Did you receive the Advance Health Care Directive Fact Sheet from your mental health provider?

If "No" please explain: \_\_\_\_\_

(If the client/significant other/guardian would like to execute an Advance Health Care Directive, please refer them to the resources identified on the Fact Sheet. If a client/significant other/guardian already has an Advance Health Care Directive, insert a copy into the client's DMH chart behind Section 2 (Consents and Notices).

**Part Two: For Client/Significant other/Guardian**

Yes No

I have been given a copy of the Advance Health Care Directive Fact Sheet and the Acknowledgement Form.

If "No" please explain: \_\_\_\_\_

\_\_\_\_\_  
Signature of client/significant other/guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature and Name (Printed) of Program/Clinic Staff

\_\_\_\_\_  
Date

\* File the original of this document in Section 2 of the chart (Consents and Notices)

This confidential information is provided to you in accordance with State and Federal laws and regulations, including but not limited to applicable Welfare and Institution Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law.

Name: \_\_\_\_\_ MIS#: \_\_\_\_\_

Agency: \_\_\_\_\_ Prov#: \_\_\_\_\_

Los Angeles County - Department of Mental Health